STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Ms. COLLINS (for herself and Ms. SMITH):

S. 3061. A bill to amend title XVIII of the Social Security Act to eliminate the 190-day lifetime limit on inpatient psychiatric hospital services under the Medicare Program; to the Committee on Finance.

Ms. COLLINS. Mr. President, I rise today with my colleague, Senator TINA SMITH, to introduce the Medicare Mental Health Inpatient Equity Act, legislation that eliminates Medicare's arbitrary 190-day lifetime cap on inpatient services in psychiatric hospitals. Given the steps that Congress has already taken to establish parity and improve coverage of mental health services, this change is long overdue, particularly as the COVID–19 pandemic has worsened the already alarming trends in the mental health of some Americans.

Notably, an estimated 13.1 million adults aged 18 or older in the United States are living with serious mental illness, representing 5.2 percent of all adults nationwide. These illnesses, such as schizophrenia and bipolar disorder, are chronic conditions that require ongoing treatment and care over a lifetime. When left untreated, they can be some of the most debilitating and destructive illnesses afflicting Americans.

Unfortunately, our current mental health system is fragmented, and these individuals all too often lack access to the care that they need. That is why I have worked to improve mental health services across the lifespan and break down barriers to treatment. The legislation I am introducing today eliminates another barrier in Medicare, the 190-day lifetime cap on inpatient services in psychiatric hospitals.

Most Medicare beneficiaries treated in inpatient psychiatric facilities qualify because of a disability. As such, this current restriction disproportionately impacts non-elderly Medicare beneficiaries—mainly those living with schizophrenia and bipolar disorder who may be diagnosed at a younger age and stay on Medicare longer as a result. Sadly, it is young adults aged 18 to 25 years who currently have the highest prevalence of serious mental illness of any age group.

Furthermore, no other Medicare inpatient service has these types of arbitrary caps, which is why elimination of Medicare's lifetime cap was a recommendation of the 2016 White House Mental Health and Substance Use Disorder Parity Task Force. While I recognize that this cap was originally intended to limit the Federal Government's role in paying for long-term custodial support of the mentally ill, keeping a cap on inpatient days at psychiatric hospitals—particularly for patients who have been living with serious mental illness from a young age—undermines patient treatment options and can lead to disruptive transitions of care.

During their life, people with serious mental illnesses may need repeated psychiatric inpatient hospital stays to manage their condition and regain quality of life in their community of choice. The 190-day lifetime limit can hurt people by arbitrarily ending coverage and can disrupt care from a provider who is most familiar with the patient. Moreover, when individuals with mental illness cannot receive care in the right setting, they often end up in hospital emergency rooms, in jails, or on the streets—leading to worse long-term outcomes for the individual, more pain and suffering for family members, and a greater cost to the taxpayer.

Outside a psychiatric inpatient hospital, it is difficult for many healthcare facilities to meet the treatment needs of those suffering with severe mental illness. Many general hospitals lack psychiatric care capacity, and there are countless examples of psychiatric boarding in emergency departments. Skilled nursing facilities may also not be best suited to provide the complex and specialized psychiatric care these beneficiaries need. Finally, too many patients find themselves receiving care in prisons, or not at all, if they are on the streets or are on long waitlists for care. As one local sheriff in Aroostook County recently told me, ''Law enforcement is not equipped to handle individuals with mental health challenges and yet we are faced with that reality every day.'' Similarly, a behavioral health provider in Presque Isle, ME, said, ''Imposing a limit may appear to reduce cost; however, the true cost-and toll-on community resources is far greater than any savings incurred by Medicare.''

On top of all of these existing challenges, it is clear the COVID–19 pandemic has increased stress and isolation, disrupted care services, and dramatically changed everyday life and even living environments for many Americans. With research pointing to greater psychological distress during the pandemic for people with mental illnesses, already a particularly vulnerable population, I fear we will be trying to make up for lost strides in behavioral health care for years to come. Now more than ever, we must work on commonsense reforms that provide parity between behavioral and physical health care, as well as strive to increase access to support and improve care coordination.

As the American Hospital Association, which endorses this bill, said, ''As we work to further integrate physical and behavioral health to better address the nation's behavioral health needs, one major obstacle to parity remains in the Medicare program—the 190-day lifetime limit on coverage for certain inpatient psychiatric treatment. With the nation's population aging and an increasing number of seniors and people with disabilities seeking inpatient care to address their behavioral health needs, now is the time to repeal this discriminatory policy and ensure that Medicare beneficiaries can receive necessary inpatient psychiatric care.''

The pandemic may have had a disastrous effect on the mental health of the Nation, but it has also led to more visibility and the understanding that individuals with serious mental illness, their families, and the communities in which they live do not have access to the care and resources they need. I hope we can use what we have learned throughout the pandemic as an opportunity to reduce stigma and make overdue reforms like removing the 190–day lifetime cap on inpatient services in psychiatric hospitals.

Our legislation, the Medicare Mental Health Inpatient Equity Act, is supported by a wide range of organizations, including the American Hospital Association and the Mental Health Liaison Group, a coalition of 57 national organizations representing consumers, family members, and mental health and addiction providers. This includes support from the National Association of Behavioral Healthcare, the American Psychiatric Association, the American Psychological Association, the National Alliance on Mental Illness, and Mental Health America.

I urge my colleagues to support this important critical legislation to bring greater mental health parity to the Medicare Program and give those suffering with serious mental illness access to the care they so desperately need.

Mr. President, I ask unanimous consent that the material be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

AMERICAN HOSPITAL ASSOCIATION,
Washington, DC, October 20, 2021.

Hon. SUSAN M. COLLINS,
Senate,
Washington, DC.
Hon. TINA SMITH,
Senate,
Washington, DC.

DEAR SENATOR COLLINS AND SENATOR SMITH: On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners—including more than 270,000 affiliated physicians, 2 million nurses and other caregivers—and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) is pleased to support your legislation, the Medicare Mental Health Inpatient Equity Act.

On the front lines of the COVID–19 pandemic, America's hospitals and health systems witness firsthand its far-reaching effects on behavioral health. The stress from unemployment or underemployment, isolation due to quarantine or COVID–19 restrictions, and grief over loved ones lost to the pandemic are possible to manifest in increases in already high rates of deaths from suicides and substance use disorder. Beyond COVID–19, we know that as a country to prioritize resources that support the behavioral health needs of the country. These investments will not only help to stymie the wave of unmet demand for behavioral health services that has been exacerbated by the COVID–19 pandemic, but also improve America's overall health.

As we work to further integrate physical and behavioral health to better address the nation's behavioral health needs, one major obstacle to parity remains in the Medicare program—the 190-day lifetime limit on coverage for certain inpatient psychiatric treatment. With the nation's population aging and an increasing number of seniors and people with disabilities seeking inpatient care to address their behavioral health needs, now is the time to repeal this discriminatory policy and ensure that Medicare beneficiaries can receive necessary inpatient psychiatric care.

We are grateful for your leadership on this issue and stand ready to work with you to enact this important legislation.

Sincerely,

STACEY HUGHES,
Executive Vice President.

MENTAL HEALTH LIAISON GROUP,
Washington, DC, October 18, 2021.

Hon. SUSAN COLLINS,
Senate,
Washington, DC.
Hon. TINA SMITH,
Senate,
Washington, DC.

DEAR SENATORS COLLINS AND SMITH: The Mental Health Liaison Group (MHLG)—a coalition of national organizations representing consumers, family members, mental health and addiction providers, advocates and other stakeholders committed to strengthening Americans' access to mental health and addiction care—is writing to express our strong support for the Medicare Mental Health Inpatient Equity Act. This critical legislation eliminates the discrimination against mental illnesses that continues to exist in the Medicare program as Medicare beneficiaries are limited to 190 days of inpatient psychiatric hospital care during their lifetime. This lifetime limit does not apply to psychiatric units in general hospitals and there is no such lifetime limit for any other Medicare specialty inpatient hospital service.

Through passage of landmark legislation, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Congress put coverage for mental health and substance use disorders on par with other medical disorders. Also, that year, Congress enacted legislation to equalize the Medicare outpatient coinsurance for mental and physical health. Despite this progress, discrimination against Medicare patients with mental health disorders who require ongoing psychiatric treatment and hospitalizations, when in crisis, continues to exist.

The Medicare Payment Advisory Commission reported that most Medicare beneficiaries treated in inpatient psychiatric facilities qualify for Medicare because of disability, hence they tend to be younger and poorer that the typical Medicare beneficiary. These Medicare beneficiaries live with serious mental illnesses (such as schizophrenia and bipolar disorder) and who are living with these disorders from a relatively young age. These illnesses are chronic and will require ongoing treatment and care over their lifetimes, including hospitalization when in crisis.

The elimination of the 190-day limit will equalize Medicare mental health coverage with private health insurance coverage, increase access for the most seriously ill, improve continuity of care and create a more cost-effective Medicare program.

The MHLG applauds your bipartisan leadership and looks forward to working with you and your staff to enact this important legislation.

Sincerely,

2020 Mom; American Art Therapy Association; American Association for Marriage and Family Therapy; American Association for Psychoanalysis in Clinical Social Work; American Association of Child & Adolescent Psychiatry; American Association of Suicidology; American Association on Health and Disability; American Counseling Association; American Dance Therapy Association; American Foundation for Suicide Prevention; American Group Psychotherapy Association; American Mental Health Counselors Association; American Nurses Association; American Psychiatric Association; American Psychoanalytic Association; American Psychological Association; American Society of Addiction Medicine; Anxiety and Depression Association of America; Association for Ambulatory Behavioral Healthcare; Association for Behavioral and Cognitive Therapies.

Centerstone; Children and Adults with Attention-Deficit Hyperactivity Disorder; Clinical Social Work Association; Confederation of Independent Psychoanalytic Societies; Depression and Bipolar Support Alliance; Eating Disorders Coalition; Global Alliance for Behavioral Health and Social Justice; International Certification & Reciprocity Consortium; International OCD Foundation; International Society for Psychiatric Mental Health Nurses; The Kennedy Forum; Maternal Mental Health Leadership Alliance; Mental Health America; NAADAC, the Association for Addiction Professionals; National Alliance on Mental Illness; National Alliance to Advance Adolescent Health; National Association for Behavioral Healthcare; National Association for Children's Behavioral Health.

National Association for Rural Mental Health; National Association of County Behavioral Health and Developmental Disability Directors; National Association of Pediatric Nurse Practitioners; National Association of Social Workers; National Association of State Alcohol and Drug Abuse Directors (NASADAD); National Association of State Mental Health Program Directors; National Board for Certified Counselors; National Council for Mental Wellbeing; National Disability Rights Network; National Federation of Families; National League for Nurses; National Register of Health Service Psychologists; NHMH—No Health without Mental Health; Psychotherapy Action Network; Residential Eating Disorders Consortium; Schizophrenia & Psychosis Action Alliance; Treatment Communities of America; Vibrant Emotional Health; Well Being Trust.

SUBMITTED RESOLUTIONS

SENATE CONCURRENT RESOLUTION 16—COMMEMORATING THE 30TH ANNIVERSARY OF OPERATION PROVIDE COMFORT

Mr. VAN HOLLEN (for himself and Mr. RUBIO) submitted the following concurrent resolution; which was referred to the Committee on Foreign Relations:

S. CON. RES. 16

Whereas, after the uprising against Saddam Hussein in March 1991, Hussein turned tanks and helicopter gunships on the defenseless citizens of Iraqi Kurdistan;

Whereas, overwhelmed by the superior firepower of the Hussein regime, and having already experienced the genocidal death of approximately 200,000 Iraqi Kurds, the wanton destruction of approximately 4,500 Iraqi Kurdish villages, and deadly chemical bombardment, hundreds of thousands of Iraqi Kurdish men, women, and children fled to the northern and eastern borders of Iraq, fearing that the regime would use poison gas against them, as during the Anfal campaign and in Halabja only 3 years before;

Whereas, at one point in the early days of the 1991 refugee crisis, the daily death toll of fleeing Iraqi Kurds exceeded 1,000, with victims having no time to gather any possessions or winter protective gear and thus succumbing to exposure, malnutrition, and disease;

Whereas the United States, in response to the unfolding human catastrophe, led what became the largest humanitarian operation of its kind ever, Operation Provide Comfort, delivering humanitarian relief and enforcing a no-fly zone;

Whereas Operation Provide Comfort saved the lives of countless thousands of Iraqi Kurds from near certain death on the freezing and rugged border mountains of Iraqi Kurdistan;

Whereas, to this day, Iraqi Kurds credit United States-led Operation Provide Comfort, particularly the no-fly zone that protected the Iraqi Kurdish people until 2003, for helping support security and stability in Iraqi Kurdistan;

Whereas Iraqi Kurdistan has long served as a safe haven for people fleeing conflict and religious and political persecution; and

Whereas the Kurdistan Regional Government and the Kurdish Peshmerga remain steadfast partners of the United States in the fight against extremism and terrorism: Now, therefore, be it

Resolved by the Senate (the House of Representatives concurring), That Congress—

(1) commemorates the 30th anniversary of Operation Provide Comfort;

(2) recognizes and honors the heroic soldiers, diplomats, political leaders, and coalition partners of the United States who implemented Operation Provide Comfort;

(3) recognizes and honors the bravery of the nearly 2,000,000 Iraqi Kurdish women, children, and men who struggled to survive starvation and exposure, welcomed the aid that came, and embraced the opportunity for a new life;

(4) encourages Iraqi Kurdish leaders to continue to uphold the values of democracy, human rights, and freedom that have made Iraqi Kurdistan an oasis in a troubled region; and

(5) reaffirms—

(A) the strong partnership between the United States and the Iraqi Kurds, which exists in complementarity with the United States' strong partnership with the Government of Iraq; and

(B) the enduring respect and support of Congress for Iraqi Kurdish friends of the United States who courageously stand with the United States in shared opposition to extremism and terrorism.

AMENDMENTS SUBMITTED AND PROPOSED

SA 3868. Mrs. GILLIBRAND submitted an amendment intended to be proposed to amendment SA 3867 submitted by Mr. REED and intended to be proposed to the bill H.R. 4350, to authorize appropriations for fiscal year 2022 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table.